SEER SINQ's

Finalized December 2010

Question: 20100104

Status
Final

Question
Grade--Heme & Lymphoid Neoplasms: If a pathology report is read as AML with aberrant T cell antigen expression, isn't that enough to make the grade T cell? I used Rule G2 and coded it to a T, but I just want to make sure I am reading this right.

Discussion

Answer
Yes, code to T-cell. The T cell receptor, or TCR, is a molecule found on the surface of T lymphocytes (or T cells).

History

Last Updated
12/20/10

Question: 20100102

Status
Final

Question
MP/H Rules/Behavior--Breast: How should behavior be coded when a biopsy shows in situ carcinoma with a focus suspicious for invasion and a subsequent excision/resection shows in situ carcinoma only?

Discussion

Answer
Code this case as in situ. The specimen from the excision/resection is the more reliable source for determining behavior, compared to a biopsy, especially in this case where the behavior is ambiguous on the biopsy.

History

Last Updated
12/20/10

SEER SINQ's

Finalized December 2010

Question: 20100101

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Patient was diagnosed in the blast phase of CML by bone marrow biopsy 4/2010, failed gleevac and progressed to the accelerated phase of CML in 10/2010. I am assuming this is NOT a new primary as this is not addressed in the hematopoetic rules. If I am incorrect, what am I missing?

Discussion

Answer
You are correct. If you notice, CML-blast phase, and CML-accelerated phase are synonyms for CML (the same disease). The gleevac is given to prevent or delay progression to the accelerated phase.

History

Last Updated
12/10/10

Question: 20100100

Status
Final

Question
Primary site/Histology--Heme & Lymphoid Neoplasms: How should we code the site and histology for Langerhans cell histiocytosis? For example, Langerhans cell histiocytosis diagnosed from excisional biopsy, T8 vertebral bone. No other tissue biopsy. The doctor's confirmation is malignant, but Langerhans cell histiocytosis, NOS is listed as /1 (borderline) in ICD-O-3.

Discussion

Answer
Do not use the ICD-O-3 to look up histology codes for cases diagnosed in 2010 and later. Enter "langerhans" in the Hematopoietic DB search. The ICD-O-3 code is 9751/3 which is reportable. Next see the abstractor notes for Langerhans cell histiocytosis. The abstractor notes say lytic bone lesions are the most common primary site. Code the primary site to bone, vertebral.

History

Last Updated
12/10/10

SEER SINQ's

Finalized December 2010

Question: 20100099

Status
Final

Question
Histology--Heme & Lymphoid Neoplasms: Could you please clarify a question I had regarding the histology pre-BALL and code 9836/3? Should I code all cases diagnosed after 2010 with 9836/3 to 9811/3? For example: Bone marrow biopsy on Jun 01/2010 with precursor B acute lymphoblastic leukemia, and I found code 9836/3 from Module 3 PH 11. But when I looked up in Hemato DB for 9836/3, the abstractor notes say: "For cases diagnosed 2010 and later, code pre-BALL to B-lymphoblastic leukemia/lymphoma, NOS 9811/3 and a number of B lymphoblastic leukemia/lymphomas with genetic abnormalities."

Discussion

Answer
For cases diagnosed 2010 and later, use code 9811/3, the new classification for pre-BALL. The manual will be changed in the next revision to 9811/3.

History

Last Updated
12/10/10

Question: 20100098

Status
Final

Question
Primary site/Histology--Heme & Lymphoid Neoplasms: Bone marrow biopsy on 6/18/2008 and the final diagnosis on the path report is small B cell leukemia, most consistent with mantel cell leukemia. ICD-O-3 does not list a histology code for small B cell leukemia or mantle cell leukemia. What histology code is used for this diagnosis and would the primary site be coded to bone marrow?

Discussion

Answer
Code the histology to mantle cell lymphoma and the primary site to bone marrow.

Mantle cell lymphoma can present in a leukemic phase. The only code available is for mantle cell lymphoma and the

only primary site that could be coded would be bone marrow.

The same would be done for a case diagnosed in 2010 or later.

History

Last Updated
12/10/10

Question: 20100097

Status
Final

Question
Primary site--Heme and Lymphoid Neoplasms: Primary effusion lymphoma, site is not indicated. Would I code this to C779?

Discussion

Answer
How was this lymphoma diagnosed? The majority of cases arise in body cavities. If the diagnosis was made by cytologic examination of fluid from a body cavity, follow these directions: When a primary site is not listed in the primary site box, consult the abstractor notes. The abstractor notes state that the majority of cases arise in body cavities such as the pleural, pericardial, and peritoneal cavities. Because there are no ICD-O-3 codes for the pleural space, pericardium, or peritoneal cavity, code the primary site to pleura C384 when the neoplasm arises in the pleural cavity, to pericardium C380 when it occurs in the pericardium, and to peritoneal cavity C482 when it occurs in the peritoneum. There are also instructions for extra-cavitory tumors. Less commonly, primary effusion lymphoma occurs in the GI tract, lung, CNS or lymph nodes. If any of these sites were the source of the diagnostic cytology or biopsy, code that primary site. There must be a cytology, biopsy, or scan that diagnosed this disease.

History

Last Updated
12/13/10

SEER SINQ's

Finalized December 2010

Question: 20100096

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Would you please walk me through the process of determining if this is one or two primaries? 09/30/10: Lymph node, left supraclavicular, excisional biopsy: Follicular lymphoma, grade I. 10/11/10: Soft tissue, submitted as "lymph node", mesenteric, biopsy: Large B-cell lymphoma. The findings are consistent with a large cell transformation of the patient's previously diagnosed follicular lymphoma

Discussion

Answer
The follicular lymphoma (FL) was diagnosed on 9/30/10 and the diffuse large B-cell lymphoma (DLBCL) was diagnosed on 10/11/10. The steps to determine whether this is a single primary or multiple primaries begin with using the Hematopoietic DB.

Step 1: Look up "FL" in the hematopoietic DB to get a provisional ICD-O-3 code. Also check the transformation information. FL transforms to DLBCL which means you have an acute and chronic disease diagnosed within 21 days.

Step 2: Look up DLBCL in the Hemato DB.

Step 3: Reportability rules: Both ICD-O-3 codes are in the reportability range.

Step 4: MP rules: Use rule M8 Chronic and acute disease diagnosed within 21 days and two positive bone marrows, one confirming chronic disease, the other confirming the acute disease.

We will be modifying this rule to state two biopsies or two bone marrows in the upcoming revision.

History

Last Updated
12/10/10

SEER SINQ's

Finalized December 2010

Question: 20100095

Status
Final

Question
MP/H Rules/Multiple primaries--Kidney, renal pelvis: Invasive TCC of the bladder diagnosed in 2004. Never disease free. 2/18/10 -- left renal pelvis wash with urothelial carcinoma high grade. On 4-7-10 -- nephroureterectomy which revealed high grade urothelial carcinoma with sarcomatous and squamous differentiation invading through pelvic wall and perihilar soft tissue. Is this a new renal pelvis primary?

Discussion

Answer
The renal pelvis is a new primary per rule M7. M7 will be better explained in the revised MP/H rules, but the rationale is that no field effect was present for more than 3 years. Although the bladder CA continued to recur, there were no other organs involved until 2010. M7 is intended to make the renal pelvis a new primary because there was no field effect (no organs other than bladder involved) for more than 3 years.

History

Last Updated
12/10/10

Question: 20100094

Status
Final

Question
Primary site--Heme & Lymphoid Neoplasms: How should primary site be coded for a marginal zone lymphoma found in peripheral blood? There was no additional workup (scans, etc) for this case. There does not seem to be a PH rule that applies. Should we consider peripheral blood as equivalent to bone marrow and use PH32?

Discussion

Answer
Code the primary site to bone marrow. Our hematopoietic specialty physicians state that involvement of peripheral blood is equivalent to bone marrow involvement because the marrow produces blood. In the absence of any other involvement, this is a bone marrow primary using Module 7 (Coding primary sites for lymphomas) PH32: Code the primary site to bone marrow when the only involvement is bone marrow.

History

Last Updated 12/10/10

SEER SINQ's

Finalized December 2010

Question: 20100093

Status
Final

Question
MP/H Rules/Multiple Primaries: How was Rule M10, Other Sites, developed and why? What is the expected outcome, or result? I have a particularly hard time understanding this rule when I come to recurrent soft tissue sarcomas. I would just love to understand why any recurrence after 1 year is considered a new primary, as opposed to a recurrence.

Discussion

Answer
Rule M10, tumors occurring more than one year apart are multiple primaries, was developed to differentiate a new primary from a recurrence. The rule was developed with the concurrence of the CoC site-specialty physicians and the SEER consulting pathologist. There was agreement between all of the CoC site teams and the consulting pathologist that statements of recurrence should not be relied upon to rule out a new primary. The time limits for each site were set based on information from peer-reviewed articles on tumors occurring in the same site and studies using molecular studies to confirm whether or not the tumors were histologically similar. Determination of the time limit for the "other sites" rules was probably the most difficult because so many sites are involved. However, the specialty-physicians felt that one year was an appropriate length of time to apply to these sites.

History

Last Updated
12/10/10

Question: 20100092

Status
Final

Question
Histology--Heme & Lymphoid Neoplasms: Bone marrow biopsy performed which showed acute myeloid leukemia, C421 and also marrow involvement by follicular lymphoma. No other studies done, no chemo given and patient expired shortly after diagnosis. Do I code the follicular lymphoma as C779?

Discussion

Answer
Code the primary site to bone marrow using rule PH32. Code the primary site to bone marrow (C421) when lymphoma is present only in the bone marrow. Note: All available physical exams, scans, and other work-up must be negative for lymph node, tissue, or organ involvement.

History

Last Updated 12/10/10

SEER SINQ's

Finalized December 2010

Question: 20100091

Status
Final

Question
Reportability/Histology--Heme & Lymphoid Neoplasms: Chronic myelogenous leukemia diagnosed in 1997. In Feb 2010 the disease went into a blast crisis with myeloid markers and patient received induction chemotherapy and went back to a chronic phase. I have to capture the disease in 2010 according to the manual, but what histology code would be used for the 2010 -- 9875/3 or 9861/3?

Discussion

Answer
The blast phase is not recorded as a new primary because this disease does NOT change histologies.

It is not clear which chronic myelogenous leukemia (CML) this patient has. Each CML is unique in that it has a blast phase without the histology itself changing. See the abstractor notes on any of the chronic myelogenous leukemias.

History

Last Updated
12/07/10

Question: 20100090

Status
Final

Question
MP/H Rules/Histology: What is the correct histology for the following pathologic diagnosis?

Poorly differentiated endometrioid adenocarcinoma intermixed with osteoid sarcomatous component, consistent with malignant mixed mullerian tumor with heterologous (osteosarcoma) elements.

Following the MP/H rules for other sites, there is no mixed code for these histologies, so the histology with the numerically higher code would be coded per H17 - malignant mixed mullerian tumor 8950/3. Is this synonymous carcinosarcoma?...Should this be coded as 8980/3 rather than 8950/3?

Discussion

Answer
Code to 8980/3, carcinosarcoma. Recent literature states that carcinosarcoma is synonymous with mixed mullerian tumor. Mixed mullerian tumor is an obsolete term and should not be used.

Last Updated 12/09/10

SEER SINQ's

Finalized December 2010

Question: 20100089

Status
Final

Question
Primary site--Heme & Lymphoid Neoplsams: I have question regarding Module 6/PH 24. If the lymphoma is found initially in both lymph nodes and bone marrow and we don't have the pathology available to us (many consultation and/or class 2 cases) to determine primary site, do we automatically code this to C42.1 over C77? The abstractor's notes state it can be either bone marrow or lymph nodes. The physician only states that they are both involved.

Discussion

Answer
When you are having problems coding primary site, go to Module 7 Primary Site Rules for Lymphomas Only. See PH32 that says to code to bone marrow when ONLY the bone marrow is involved. Since both the bone marrow and LN are involved, code to LN (specific nodes if a specific region is specified; if no region is specified, code to LN, NOS C779.)

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100088

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplasms: How many primaries are there when a patient with a history of multiple myeloma in 2005 returns in 2010 with plasmacytoma, plasma cell dyscrasia, and/or relapse of multiple myeloma? See discussion.

Discussion
Pt diagnosed 2005 with multiple myeloma, status post stem cell transplant 2005, in complete remission. 2/1/10 excisional biopsy soft tissue right flank mass plasmacytoma. 3/2/10 bone marrow biopsy: consistent with plasma cell dyscrasia. Outside attending stated bone marrow biopsy consistent with relapse of myeloma. No radiologic evidence of disease elsewhere as of Feb 2010, only soft tissue right flank. Pt initially presented for post op RT to right flank, treated 3/29/10. 8/6/10 biopsy of right perinephric mass positive for plasmacytoma. 8/16/10 xray of right tibia and fibula show lytic lesion consistent with progression of myeloma.

I calculated as best I could from hemato manual and database that plasmacytoma in 2/1/10 was second primary. I don't know what or how to apply rules to perinephric soft tissue disease and right tibia lesion. Are they separate new primaries? Is all of this simply a recurrence of the original 2005 diagnosis as the attending physician states?

Answer
When you have a puzzling case such as this one, check the abstractor notes for multiple myeloma (MM). Since you already have an abstract on this case, you know the ICD-O-3 code for MM. Enter 97325/3 in the search mechanism of the heme database. Display the abstractor notes. In addition to stating that bone marrow involvement, lytic bone lesions, and bone tumor masses of plasma cells are common, there is also a statement that extramedullary (in tissue other than the bone) is a generally a manifestation of advanced disease. That is the situation for the case you cite. This is one primary, MM with advanced disease. There is no need to use the rules when the new tumor is a part of disease advancement for the original primary.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100087

Status
Final

Question
Heme & Lymphoid Neoplasms: I have two cases that I would like present to you to see if I am looking at them correctly.

Case #1 - history of marginal zone lymphoma dx in 1994 with recurrence in 2007 and 2009. Presents to our facility for bone marrow bx in May 2010 and found to have large B-cell lymphoma, transformation. First primary marginal zone lymphoma falls under the 2009 rules and second primary large B-cell lymphoma falls under 2010 rules?

Case #2 - patient diagnosed with CLL/B-cell/SLL and a diffuse large B-cell lymphoma in 2009. Both fall under 2009 rules are are one primary. Despite the patient coming into our facility in 2010 for treatment the rules are based upon diagnose date?

Discussion

Answer
Case 1: History of marginal zone lymphoma 9699/3. The first step is to check the transformation information on marginal zone lymphoma. Enter 9699/3 in the search mechanism of the hemato DB. Look at the transformation information. Marginal zone lymphoma does transform to diffuse large B-cell lymphoma (DLBCL), the 2010 diagnosis. Because the DLBCL occurred in 2010, this falls under the 2010 hematopoietic rules. Enter "DLBCL" in the search mechanism of the hemato DB. The display shows DLBCL 9680/3 and the preferred term (listed midscreen) is diffuse large B-cell lymphoma. Now you have the ICD-O-3 code for DLBCL, go to the Reportability Instructions in the hemato manual. 9680/3 falls in the reportability range. MP rules: M13 says to use the multiple primaries calculator to determine the number of primaries. Enter 9699/3 and 9680/3 into the multiple primaries calculator. The result is "New Primary." Create a new abstract for the DLBCL.

Case 2: Do not use the 2010 rules for this case. Both diagnoses were made prior to 2010. The 2010 rules are only effective for cases diagnosed in 2010 or later.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100086

Status
Final

Question
Multiple primaries/Primary site/Histology--Heme & Lymphoid Neoplasms: Should I code one or two primaries? What histology and site are suggested? Mycosis fungoides diagnosed on Feb 10, 2010. Pt returned on May 11, 2010 for bx of lymph nodes which was diagnosed as peripheral T–cell lymphoma consistent with CD 30+ large cell transformation of mycosis fungoides, no data on ALK protein.

Discussion

Answer
1. The previous diagnosis was mycosis fungoides 9700/3. Go to the hemato DB and enter 9700/3 in the search mechanism. The transformation information tells you that MF transforms to large T-cell lymphoma.

2. The next step is to use the heme DB to find a provisional ICD-O-3 code for the May diagnosis. Do a smart search by entering "large cell" into the search mechanism (these are words mentioned in both the transformation information and the May diagnosis).

3. Click on the header "Matched Term" to alphabetize the list. Scroll down until you see an appropriate diagnosis (look at the alternate names for each of these entries). You will come to anaplastic large cell lymphoma 9714/3. One of the alternate names is anaplastic large cell lymphoma CD30+. This fits the May diagnosis.

4. To check the site code, click on the disease name to display the detailed information, then display the abstractor notes. Always use the abstractor notes when you are unsure of a site/histology match. The abstractor notes say the most commonly involved extranodal sites include skin.

5. Check the reportability instructions in the heme manual: the new ICD-O-3 code is included in the reportability range.

6. Go to the multiple primary rules. Follow M13 and go to the multiple primaries calculator in the heme DB.

7. Enter both histologies 9700/3 and 9714/3 into the MP calculator. The result is "New Primary."

8. Create an abstract for the anaplastic large cell lymphoma 9714/3. If the lymph nodes were biopsied because there was a skin lesion or lesions in that region, code the primary site to skin, NOS. If the lymph nodes were randomly biopsied or if the physician noted adenopathy without any skin lesion in that area, code the primary site to lymph nodes (appropriate region).

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100085

Status
Final

Question
Primary site/Histology--Heme & Lymph Manual & DB: What are the correct primary site and histology codes for this case? Biopsy of substernal mass and pericardium showed T-cell lymphoblastic lymphoma/leukemia. There was no bone marrow biopsy. CT scan showed evidence of mediastinal and hilar adenopathy.

Discussion

Answer
The first step is to use the hemat DB to get a provisional ICD-O-3 code and verify site/histology agreement. 1. Do a "smart search" by entering only the word "lymphoblastic" in the search mechanism

2. Click on "Matched Term" on the header above the displayed terms. The terms are now alphabetized. Scroll down to "T" and you will see T lymphoblastic leukemia/lymphoma 9837/3

3. Click on the term so the information is displayed

4. Click on abstractor notes. Always use the abstractor notes when you are questioning what primary site to code. The first information says this code is effective for cases diagnosed 2010 and later. Next it says most patients present with widespread LN involvement as well as peripheral blood involvement. The skin is the most common extralymphatic site, but the disease is usually systemic involving spleen and extranodal sites including lung, liver, GI tract, and CNS.

5. Now that you have this information, go to the Hematopoietic Manual.

6. Reportability rules: 9837/3 is within the reportable range.

7. MP Rules: M2, a single histology is a single primary.

8. PH Rules: Go to module 7, rules for coding primary site for lymphomas. PH29, code the LN region when multiple lymph node chains within the same region (mediastinal and hilar) are involved. Code C771 because both mediastinal and hilar LN are coded C771.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100084

Status
Final

Question
Diagnostic confirmation--Heme & Lymphoid Neoplasms: Please clarify the statement in the hematopoietic manual on coding Diagnostic Confirmation using Code 5 vs the 2010 SEER Manual Code 3, with specific examples of diagnoses and positive tests. They seem to be in conflict or I do not understand the rule. I am confused by the sentence "Do not use the instructions that direct you to give preference to coding a histologic confirmation for the hematopoietic and lymphoid neoplasms."

Discussion

Answer
Follow the Diagnostic Confirmation instructions in the 2010 SEER manual.

That portion of the hematopoietic manual was written and published before code 3 was approved for the 2010 data. Thank you for pointing out this discrepancy. We will revise that paragraph in the hematopoietic manual in the next set of revisions. We appreciate you bringing this to our attention.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100083

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplams: How many primaries should be abstracted for this case of a longstanding history of follicular cell non-Hodgkin lymphoma that dates back to the early 1990s? Do I use the MP calculator for this case? If so, it did show this was a new primary. I wanted to be certain at what point I use the MP calculator. See discussion.

Discussion
Treated with chemotherapy and bone marrow transplantation, radiation therapy, and rituximab. Has had no evidence of recurrence. And then in 4/10, had a lesion appear on side of scalp right above left ear: B-cell lymphoma with prominent large cell component, compatible with primary cutaneous follicle center cell lymphoma.

Answer
Take the following steps when there is a history of heme/lymph neoplasm and current diagnosis of another heme/lymph neoplasm:

Step 1: Look up the historic and current diagnoses in the hematopoietic DB to get provisional ICD-O-3 codes and also to see if the new neoplasm is a transformation. Start by entering the known ICD-O-3 code for the follicular lymphoma 9690/3. Next, click display and look at the transformation information. The DB says follicular lymphoma transforms to diffuse large B-cell lymphoma. Next look up the newly diagnosed neoplasm. Do NOT enter the entire term, do a "smart search" by entering only the term or terms that are unique in this disease name. In this case, the unique word in primary cutaneous follicle center lymphoma is follicle. Enter ONLY follicle in the search mechanism. The display shows primary cutaneous follicle center lymphoma 9597/3 and the definition and abstractor notes fit the disease you are abstracting.

Step 2: Go to the reportability rules. Both ICD-O-3 codes fall into the reportable range.

Step 3: Use rule M13 because none of the previous rules fit this case. M13 tells you to use the Multiple Primaries calculator to determine the number of primaries. Enter both histologies 9690/3 and 9597/3. The result is "new primary." Abstract the primary cutaneous follicle center lymphoma as a new primary.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100082

Status
Final

Question
Ambiguous terminology/Reportability--Heme & Lymphoid Neoplasms: When a consult uses ambiguous terminology (probable MDS) and the bone marrow does not confirm the consult diagnosis, is it reportable? If so, should it be entered as MDS, NOS based upon the consult's original statement of "probable MDS"? See discussion.

Discussion
I have ambiguous terminology during an inpatient admission that states "probable MDS" by a hem/onc doctor during a consult. During this admit, a bone marrow biopsy is performed and the final diagnosis on the path report is "anemia and thrombocytopenia". This patient is not seen by a hem/onc doctor at our facility after the bone marrow biopsy, and another treating doctor (cardiologist) states "BM biopsy-not clear whether this is MDS or another etiology".

Answer
This is not reportable. In effect, the original diagnosis was a rule/out MDS diagnosis. The bone marrow proved that rule/out diagnosis was not valid.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100081

Status
Final

Question
Histology--Heme & Lymphoid Neoplasms: In order to code as multiple myeloma, does the bone marrow have to have 10% or greater when you have a doctor workup stating MM? See discussion.

Discussion
This patient had a plasmacytoma removed from the sphenoid sinus and was started on dexamethasone 4x a day and then had a bone marrow biopsy which showed 4% plasma cell. (statement in hematology notes: it can increase the rate of false negative results with a bone marrow biopsy.) Bone marrow was done 15 days after the surgery for the plasmacytoma

Workup showed with the diagnosis of MM: per statement in hematology notes: I found her having 4% blasts, atypical plasma cells in the bone marrow biopsy and also lytic lesions involving the T7 and lucencies involving L4 and L5 vertebral bodies and also the upper sacrum. The PET-CT scan did not show significant metabolic activities in those lesions. The patient had a small amount of Bence-Jones in the urine and also an abnormal kappa to lambda ratio in the serum. The ratio was 12 to 1. The beta 2 microglobulin was 1.4. The albumin in the serum was 3.4. Based on that, the patient has been diagnosed with Durie-Salmon stage III in ISS stage II multiple myeloma.

When reading the Hematopoietic rules in Module 2, PH 7-8, I note that the MM diagnosis is when the proportion of plasma cells in the bone marrow is 10% or greater, the diagnosis is multiple myeloma.

Answer
Accept the physician's diagnosis of multiple myeloma. Code the MM as a single primary using rule M7 only if there was ONLY one bone marrow biopsy. Code as multiple primaries (both the solitary plasmacytoma and MM) using rule M8 if there are TWO bone marrow biopsies.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100080

Status
Final

Question
Reportability--Heme & Lymphoid Neoplams: A patient with pancreatic cancer treated with Gemzar is now back in the hospital with thrombocytopenia and given transfusion of platelets. Is this refractory thrombocytopenia and requires another abstract? The hematopoietic database only has refractory thrombocytopenia.

Discussion

Answer
In this case, you do not have a reportable diagnosis.

Only refractory thrombocytopenia is reportable. The diagnosis of thrombocytopenia means the patient has a disorder in which there are not enough platelets. Non-malignant causes include disseminated intravascular coagulation (DIC), drug-induced non-immune thrombocytopenia, drug-induced immune thrombocytopenia, hypersplenism, immune thrombocytopenic purpura (ITP), thrombotic thrombocytopenic purpura, and infections of the bone marrow. The malignancies associated with thrombocytopenia are anaplastic anemia and myelodysplasia.

History

Last Updated
12/02/10

Question: 20100079

Status
Final

Question
Reportability--Heme & Lymphoid Neoplasms: In ICD-0-3 9970/1 = Lymphoproliferative disorder/disease, NOS. When I look this term up in the 2010 Hematopoietic Database it states that the the ICD-O-3 code is N/A. Should we be updating our ICD-O-3 books to indicate that as of 2010 9970/1 is no longer applicable?

Discussion

Answer
The N/A indicates that this is not a reportable neoplasm. There are also new codes that define lymphoproliferative disorder/disease more specifically. If you do a "smart search" by entering only the word "lymphoproliferative" into the Hematopoietic DB you will get a listing of all of the reportable terms and all of the non-reportable terms. That enables you to look at your record and compare the words in the DB to those in the record you are processing.

Last Updated 12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100078

Status
Final

Question
MP/H Rules/Histology--Lung: What is the appropriate histology code for squamous carcinoma and large cell undifferentiated neuroendocrine carcinoma, Lung?

Discussion

Answer
Apply rule H7 and code the numerically higher ICD-O-3 code, 8070/3. See Chart 1, the histology tree in lung equivalent terms. Large cell neuroendocrine carcinoma is histology code 8013/3. The other histology is squamous carcinoma, 8070/3. 8070/3 is higher numerically than 8013/3.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100077

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Does Rule M4 only apply if both diseases are present at the original diagnosis, or does it also take into account a recurrence of an old disease? The answer to this question makes a huge difference, the difference between stopping at M4 and abstracting as one disease, and going on to M13 to query the DB and find out it is two separate primaries. See discussion.

Discussion
Pt had Stage II Hodgkin dz in 2005 (all nodes above diaphragm, supraclav LN biopsied at dx), treated with complete remission. Pt comes to our facility in 2010 for suspected recurrence, supraclav LN bx shows "Recurrent Hodgkin" AND "EBV+ Diffuse Large B-cell Lymphoma", both in the same LN. I go to Heme Manual and stop at M4. This rule tells me it is a single primary and do not query the DB. It doesn't seem right, as it is not accounting for the new DLBCL.

Answer
You actually have two "diseases" to consider. The first is the 2005 occurrence of Hodgkin only. After a remission, the patient appeared with a different "disease" because there was both Hodgkin and EBV+ DLBCL present. That does not match the original diagnosis. Start by classifying the "new" disease, then compare it to the original. You correctly identified M4 as the multiple primary rule. When this rule says "same primary" it is referring ONLY to the new diagnosis that you are researching. In other words, you would not code Hodgkin and DLBCL in the same node(s) as separate primaries. Next go to the PH rules. The first module that applies to this case is Module 6, PH21 which says to code combinations of Hodgkin and non-Hodgkin in the same node(s) to 9596/3, composite lymphoma. Enter 9596/3 in the search mechanism of the Hemato DB and you will see the preferred term: B-cell lymphoma, unclassifiable with features intermediate between DLBCL and classical Hodgkin lymphoma. This is the new WHO classification for this disease. I have noted that the older term "composite lymphoma" from the ICD-O-3 is not listed. We will add in the next revision.

Now you have an ICD-O-3 code that fits the new diagnosis, 9596/3 and an ICD-O-3 code for the previous diagnosis of Hodgkin disease, NOS (now called classical Hodgkin), 9650/3.

Enter those codes into the Multiple Primaries calculator. The result is that this is a new primary. Create a new abstract for the 2010 diagnosis with a primary site of lymph nodes and histology 9596/3.

Rule M4 cautioned you not to consult the DB at that point because you would have entered Hodgkin and DLBCL in the Multiple Primaries calculator. When you got the reply "new primary" you would have abstracted the second occurrence as DLBCL 9680/3 which would not have been correct.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100076

Status
Final

Question
Reportability--Heme & Lymphoid Neoplasms: Is Thrombocytosis, NOS reportable? (It does not specifiy Primary, Idiopathic, Essential).

Discussion

Answer
Unless the disease is specified as primary, idiopathic, essential, or the physician states there is a myeloproliferative neoplasm, the term thrombocytosis, NOS is not reportable. Thrombocytosis, NOS is the presence of high platelet counts in the blood. Thrombocytosis can be associated with chronic infections and other diseases as well as with myeloproliferative disease.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100075

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplasms: For the case detailed under "Discussion," do I abstract a 2nd primary, B lymphoblastic leukemia/lymphoma, NOS with histo code 9811/3 or not? See Discussion.

Discussion
1/27/10 BM CML BCR/ABL+ FISH positive for BCR/ABL and cytogenetics showing the t(9;22)q34q11.2 translocation. Treated with Imatinib. 4/15/10 BM: B-acute lymphoblastic leukemia (Blast phase of CML).

Rule M10 says we have a new primary. But note 2 says transformations are defined in the HemaDB. When I look up CML in the HemaDB, it says there are no transformations and the abstractor notes say CML has three phases: chronic, accelerated, and the blastic phase or blast crisis. The accelerated phase can last weeks to months. In the chronic phase the involvement is usually limited to blood, bone marrow and spleen although the liver may be infiltrated. During the blastic phase, lymph nodes and tissue may be involved. The blastic phase is a disease progression from the chronic phase. The disease, however, remains the same histology, chronic myelogenous leukemia.

Answer
This is a new primary. The information listed for CML is accurate, because there is a blast phase which can be confusing. This case, however, does not meet the criteria of having the same histology, CML.

Enter the unique phrase or words into the DB search mechanism (Do not enter the entire term). In this case, a "smart search" would be entering t(9;22) into the search mechanism. The first disease displayed is mixed phenotype acute leukemia with t(9;22)(q34;q11.2);BCR-ABL1, 9806/3. This matches your case exactly.

Note 2 under M10 actually means that you use all of the information in the DB. When you do not see the disease in the transformation information, use the multiple primaries calculator. The MP calculator shows that the mixed phenotype acute leukemia is a new primary. In this case, this is not a disease the hematologists listed as a transformation, instead it was a new primary. Check both the transformation information and the MP calculator when you are questioning whether or not to code a new primary.

History

Last Updated
12/10/10

SEER SINQ's

Finalized December 2010

Question: 20100074

Status
Final

Question
Laterality--Melanoma: In a melanoma case would the term "mid" be equivalent to midline for the coding of laterality when the site is back (trunk)?

Discussion

Answer
Yes. When the location is described as mid-back, or mid-chest, with no indication of left or right, assign laterality code 5.

History

Last Updated
12/20/10

Question: 20100073

Status
Final

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Would you please walk me through the rules on how you would determine the number of primaries for this case?

Patient had bone marrow biopsy 4-7-10 which documents myelodysplastic syndrome - refractory anemia (RAEB2) with some features of a myeloproliferative neoplasm. Then had a bone marrow biopsy 7-27-10 which revealed progression to acute myelogenous leukemia with 40% blasts in marrow.

Discussion

Answer
You have several important pieces of information. There were two bone marrows, one of which confirmed the chronic disease, a second that confirmed the acute disease. The dates of the bone marrows are more than 3 months apart.

Go to the MP rules. M7 does not fit because it specifies that the diagnosis is within 21 days and also that there is only ONE bone marrow.

M8 again applies to diagnoses within 21 days, so it does not fit.

M9 does not fit because it specifies that the diagnoses are within 21 days and that there is no documentation of a BM.

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M10 says abstract as multiple primaries when a neoplasm is originally diagnosed in a chronic phase (MDS RAEB2) and an acute disease (AML)is diagnosed more than 21 days later. This is the rule that fits your case. Abstract two primaries, the first RAEB2 and the second AML.

History

Last Updated **12/06/10**

Question: 20100072

Status
Final

Question
Histology/Reportability--Heme & Lymphoid Neoplasms: How do I code this? Dx is Follicular lymphoma in situ of the gallbladder. Our chief of pathology states that this is a recently identified pathologic entity. The software does not like 9690/2, and there are multiple edits including SEER/CS.

Discussion

Answer
Currently, lymphoma in situ is not reportable. It is true that this is a recently identified pathologic entity. Our experts say that there is still some controversy to be ironed out regarding the criteria for identifying an in situ lymphoma. Their recommendation was to wait until clear guidelines had been established for the pathologists before we start collection of in situ lymphomas. We anticipate collecting these entities in the future.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100071

Status
Final

Question
Multiple primaries/Histology--Heme & Lymphoid Neoplasms: Is it correct to code multiple myeloma for the following? Diagnosis of solitary plasmacytoma of R frontal skull in 2/10 that was totally resected (the cranial specimen was read as plasmacytoma). Patient received RT. While undergoing RT, patient seen by Med Oncologist who did a bone marrow biopsy with 10-15% plasma cells and was said to have smoldering myeloma. Treatment by watchful waiting. In August patient has multiple lytic lesions and is starting systemic tx.

I chose Rule M13 and when I plugged the two histologies into the heme database calculator (9731/3 first and 9732/3 second) it came up with two primaries. Am I doing something wrong? Which M rule is the correct rule to choose?

When the manual states "Use the Hematopoietic DB to determine the primary site and histology when PH1-PH39 do not apply". This means the calculator not the database itself, right? By the old rules this is one primary. Did this change?

Discussion

Answer
The MM is a second primary. The steps you would use to determine this are

1. look up osseous plasmacytoma and multiple myeloma in the Hemato DB to get provisional histology codes and to check the transformation information. First do a smart search by entering ONLY the unique word "osseous." The display immediately shows osseous plasmacytoma 9731/3. Display the information to check the transformation box. The DB confirms that osseous plasmacytoma does transform to multiple myeloma. Next do a smart search on multiple myeloma by entering ONLY the unique word "multiple." The provisional ICD-O-3 code is 9732/3. Alternate names for this disease are evolving MM and smoldering MM.

2. Go to the reportability rules. Both of the codes are within the reportable range.

3. Go to the MP Rules. You have determined that this case is a chronic disease (plasmacytoma) transforming into an acute disease (MM). Apply M10 - abstract as multiple primaries when originally diagnosed in a chronic phase and there is a second diagnosis of an acute phase more than 21 days after chronic diagnosis. See note 1 which says "This is a change from previous rules." Note that the MP rules and the MP calculator in the Hematopoietic DB agree.

When the rules tell you to go to the DB to determine the histology and primary site, you use the DB information (don't forget the abstractor notes). The multiple primaries calculator is for determining the number of primaries to abstract. Always use the M rules before using the MP calculator.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100070

Status
Final

Question
Histology--Heme & Lymphoid Neoplasms: What is the histology code for follicular lymphoma, grade 2 of 3, predominantly nodular?

Discussion

Answer
Code follicular lymphoma grade 2 9691/3. Nodular lymphoma is an obsolete term once used to describe follicular lymphoma.

History

Last Updated
12/02/10

Question: 20100069

Status
Final

Question
Primary site--Heme & Lymphoid Neoplasms: Pt has a colonoscopy done 5/26/10. Ulcers in cecum, ascending, transverse, descending & sigmoid colon. Diagnosis is 9971/3 post-transplant lymphoproliferative disorder. What is the primary site?

Discussion

Answer
Assign code C189, Colon, NOS.

Look up post transplant lymphoproliferative disorders in the hematopoietic DB. Check the abstractor notes for a site/histology confirmation. The abstractor notes state that the GI tract is a common site for this neoplasm. Code to colon, NOS C189. Overlapping lesion C188 would not be used since there are multiple ulcers. The .8 code is used for a single lesion that overlaps subsites.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100068

Status
Final

Question
Histology--Heme & Lymphoid Neoplasms: What histology would I use to report this case? The Hemonc physician is calling it JAK-2 positive myeloproliferative disorder. It is never called acute or chronic. JAK-2 test was positive for mutation, bone marrow states "morphological features can be seen in myeloproliferative neoplasm." Flow cyto states "The flow data demonstrate neutrophilia with left shift. Lymphocytes are composed of a mixed population of T and B-cells with some atypical B-cells." The patient is then treated with Hydrea.

Discussion

Answer
Code as myeloproliferative/myelodysplastic neoplasm, unclassifiable 9975/3 (new code implemented in 2010). The process for this decision was: entering MPN into the search mechanism in the Hemato DB. When you click on the term "myeloproliferative disease, NOS, you see that the preferred term is Myelodysplastic/myeloproliferative neoplasm, unclassified. Next click on the abstractor notes which tell you this code is now used for MPN NOS, and MPN unclassifiable. The third paragraph explains when the disease is diagnosed very early, it may manifest symptoms of two or more specific myeloproliferative neoplasms. That is the scenario you describe. JAK-2 is positive, but the physician does not designate PV or ET. Hydrea is given for both PV and ET. In the future, the specific type of MPN may be diagnosed. In the interim, code the only diagnosis you have, MPN, NOS.

History

Last Updated
12/02/10

Question: 20100067

Status
Final

Question
MP/H rules/Reportability: I&R # 45622 asked if mucinous borderline tumor with intraepithelial carcinoma & focal microinvasion is reportable. The answer was that this is not reportable. According to MPH, FORDS, and Collaborative Stage, intraepithelial carcinoma is in situ, behavior code 2, and is reportable. Has this changed? See discussion.

Discussion
I have a case where the pathology states: Omentum: mixed epithelial borderline tumor with multiple foci of intraepithelial carcinoma. Peritoneal fluid for cytology: neoplastic cells present; low grade serous neoplasm. Lymph nodes, right pelvic: one lymph node harboring implants of serous borderline tumor and endosalpingiosis within the subcapsular sinus. Bilateral fallopian tubes and ovaries: mixed epithelial borderline tumor with multiple foci of intraepithelial carcinoma involving ovarian surface and serosal surface of the tube. Detached fragment of borderline tumor within the tubal lumen. Uterus, cervix, and segment of colon: mixed epithelial borderline tumor with multiple foci of intraepithelial carcinoma involving parametrial and paracervical tissue, cul de sac, uterine and colonic serosa. Nine pericolonic lymph nodes negative for tumor. Stage III.

Answer
This is reportable because there is a diagnosis of carcinoma (intraepithelial carcinoma).

History

Last Updated 12/02/10

Question: 20100066

Status
Final

Question
MP/H Rules/Multiple Primaries--Breast: We have a breast case with two masses in the same breast and different histology codes and different sizes. Should this be two primaries or should we go by the largest size or higher histology for a single primary?

(1) Size 1.7 cm for the largest tumor size but histology is colloid carcinoma. Histology code: 8480/3.

(2) Size: 1.5 cm. with Histology code 8523/3 Colloid with infiltrating ductal carcinoma.

Discussion

Answer
Abstract this case as two primaries.

Mucinous/colloid carcinoma of the breast is rare. The first tumor you describe (1.7 cm) fits this criteria since the pathologist simply says mucinous carcinoma.

The diagnostic criteria for mucinous carcinoma is that pools of extracellular mucin make up at least 1/3 of the volume throughout. If focal areas are not at least 33% mucinous, the designation is a mixed mucinous/ductal. That fits the second tumor (1.5 cm).

For this case, you must get the histology codes for both tumors in order to use the Multiple Primary rules. Per H14 the first tumor is coded mucinous carcinoma 8480/3. Per H17 the second tumor is coded duct carcinoma mixed with any other carcinoma 8523/3. Now go to the MP rules. Per M12 abstract multiple primaries because the ICD-O-3 histology codes are different at the second and third digit.

History

Last Updated
12/02/10

SEER SINQ's

Finalized December 2010

Question: 20100065

Status
Final

Question
Reportability--Heme & Lymphoid Neoplasms: Is myeloproliferative syndrome NOS reportable under the new hematopoiectic rules? We find myeloproliferative disease or myelodysplastic syndrome but not specifically myeloproliferative syndrome NOS.

Discussion

Answer
Myeloproliferative syndrome and the myeloproliferative diseases were used in the past to describe myeloproliferative neoplasms. Although the term is not currently used to describe this disease, we will add the synonyms "myeloproliferative syndrome" and "myeloproliferative disease" to the database synonyms for MPN, NOS.

History

Last Updated
12/02/10

Question: 20100064

Status
Final

Question
Histology--Heme & Lymphoid Neoplasms: Acute lymphoblastic leukemia (ALL) and/or pre B ALL; the database has two (2) histo codes: 9811/3 and 9836/3. Which do I use??

Discussion

Answer
Assign code 9811/3.

See the abstractor notes when in doubt. The abstractor notes for 9811/3 say this code is effective for cases diagnosed 2010 and later. Abstractor notes for 9836/3 say for cases diagnosed 2010 and later, code Pre-BALL to 9811/3.

History

Last Updated
12/13/10

SEER SINQ's

Finalized December 2010

Question: 20100063

Status
Final

Question
Primary Site-–Lung: Can you use a lung subsite code for a histologically confirmed lung primary when a CT scan indicates a sized mass located in one lobe of the lung as well as "too numerous to count nodules" through one or both lungs? See discussion.

Discussion
For example, chest CT shows "1.6 cm RUL suspicious mass and too numerous to count nodules throughout both lungs." Core biopsy of mass in the RUL compatible with adenocarcinoma.

Answer
For lung primaries with one large mass and numerous nodules, code the primary site to the subsite where the large mass is located. For your example, code primary site to upper lobe (C341). Note: this answer does NOT mean that the other nodules are primary or metastatic cancer.

History

Last Updated
12/13/10

SEER SINQ's

Finalized December 2010

Question: 20100054

Status
Final

Question
MP/H Rules/Multiple primaries--Breast: Does the following represent one or two primaries?

Pathology: Infiltrating mammary carcinoma with mixed tubular and lobular features, 2.3 cm. Low grade cribriform in situ ductal carcinoma. Paget Disease of the overlying skin with ulceration.

See discussion.

Discussion
According to SINQ 20081134 the histology would be 8524 if this is one primary.

Answer
This is a single primary.

In order to determine single or multiple primary for this case, you must decide upon the correct histology code for the underlying tumor. Using rule H9, ignore the DCIS.

See Table 3 in the equivalent terms and definitions. Infiltrating lobular, tubular, and Paget are coded to a single histology code (8524/3). Our current multiple primary rules do not say infiltrating lobular and tubular and Paget are a single primary. This was an omission and will be corrected in a future revision. Thank you for bringing this omission to our attention.

History

Last Updated
12/14/10

Question: 20091085

Status
Final

Question
MP/H Rules/Histology--Breast: How is histology coded for a breast primary with a final diagnosis of "infiltrating duct carcinoma with apocrine features"?

Discussion
I & R has conflicting answers: #25719 (dated 3/17/2008) says per rule H12 this is 8401/3 but #23347 (dated 8/12/07) says per rule H16, this is 8523/3.

Answer
Assign histology code 8401/3 [apocrine adenocarcinoma] according to rule H12. Apocrine is a type of duct carcinoma, see table 1. Code 8401 should be listed in Rule H12. Apocrine should be removed from table 3. These corrections will

appear in the revised version of the rules.

History

Last Updated 12/13/10

Question: 20091021

Status
Final

Question
Behavior/Reportability--GIST: Address the issue of reportability of GIST tumors.

Discussion
According to pathologist and oncologist, the terms "malignant" and "benign" do not apply to GIST. Rather, the term "high risk for malignant behavior" is used. This is based on tumor size: greater than 5 cm and mitotic activity: greater than 5 mitoses/50 hpf.

Answer
Do not report the case to SEER if it does not satisfy the criteria for reportability. According to the current reportability criteria, malignant GIST (8936/3) is reportable to SEER. GIST coded to 8936/0 or 8936/1 is not reportable. If your pathologist will not indicate "malignant" or "benign," code 8936/1 applies according to ICD-O-3 and, therefore, these are not reportable to SEER.

History

Last Updated
12/20/10

SEER SINQ's

Finalized December 2010

Question: 20100103

Status
Final

References
Source 1: **2010 SEER Manual**
pgs: **1**
Notes:
Source 2:
pgs:
Notes:

Question
Reportability--Corpus uteri: For cases diagnosed 2010 and forward, is gestational trophoblastic neoplasia reportable if there is no mention of metastasis but the patient has been treated with chemotherapy?

Discussion
Per SINQ 20021106, for tumors diagnosed prior to 2007, a clinical diagnosis of metastatic gestational trophoblastic disease was to be coded to histology 9100/3 [Choriocarcinoma]. "Gestational trophoblastic neoplasia includes the diagnosis of choriocarcinoma."

Answer
Do not report gestational trophoblastic neoplasia unless stated to be malignant.

History

Last Updated
12/29/10